Recertification Process

Job Aid

Overview

A home health certification period is an episode of care that begins with a start of care visit and continues for 60 days. If at the end of the initial episode of care, the patient continues to require home health services, a **recertification** is required.

Components of a Recertification

The recertification includes the following components:

- A comprehensive assessment that is completed in the last five (5) days of the ending 60-day episode of care and prior to the start of the forthcoming 60-day episode.
- Completion of a recertification follow-up OASIS comprehensive assessment that includes limited data elements.
- Completion of a new plan of care, certification, and physician orders signed by the patient's primary physician. Orders from all physicians involved in the plan of care should be integrated into the plan of care.
- Calculation of a new episode payment for the upcoming 60-day episode of care based on OASIS results.
- A physician certification estimating how much longer the skilled services will be required.

The recertification may be completed by any ordered discipline qualified to perform OASIS comprehensive assessments. If a billable visit is not scheduled to occur during the last five days of the

ending episode of care, a non-billable visit must be made to complete the comprehensive assessment. A physician's order is not necessary for a non-billable, assessment-only visit.

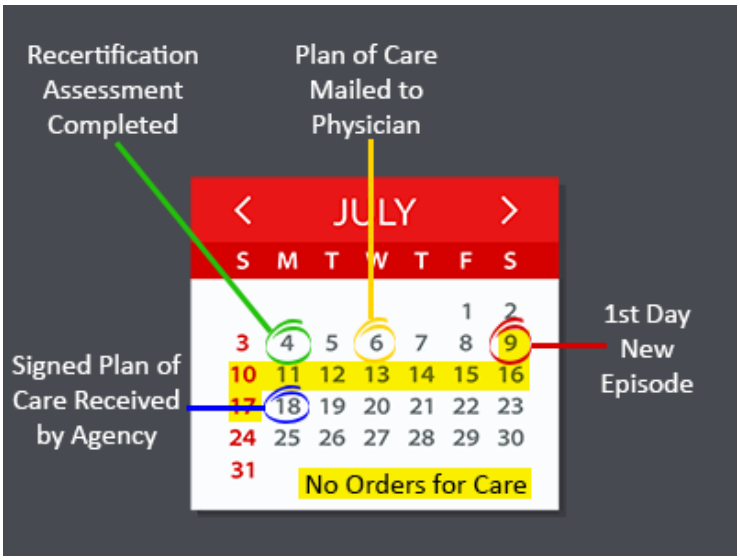
Calculating the Five-Day Window

When calculating the five-day time frame for completion of the recertification assessment, the 60th day of the ending episode of care is considered day 5, and counting backward, the first day of the five-day window is day 1. The recertification assessment may be completed on any of these five days.

Five-Day Window to Complete Recertification Assessment

Maintaining Compliance with Physician Orders

Because the plan of care generated from the recertification assessment becomes the orders for services in the new certification period, clinicians must ensure the medical record demonstrates that the physician is authorizing the orders and plan for services.



Since the timeframe between generation of the plan of care and the start of the new certification period is very short (5 days), submitting the plan of care by mail and then waiting for it to be returned signed, may place the agency out of compliance of following physician orders. This is because there may be a period of time where neither the signed plan of care nor a verbal order is present in the agency for the new certification period.

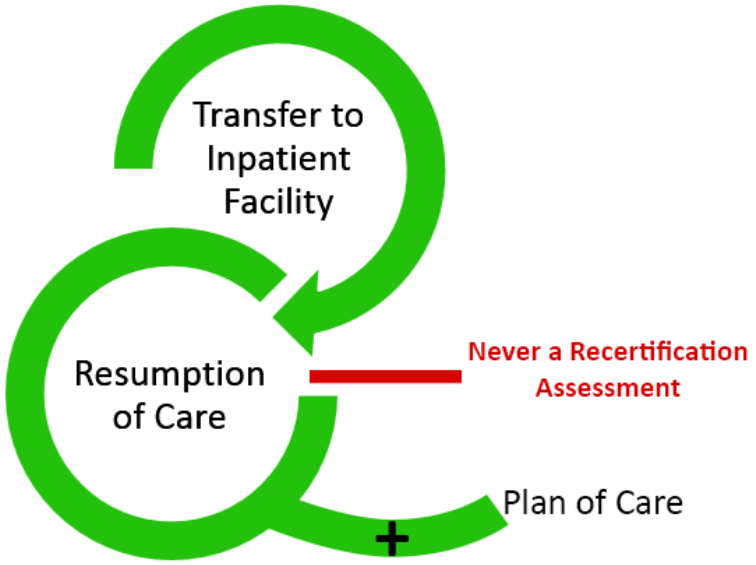
To prevent a potential citation, clinicians should ensure that there is documentation supporting the fact that the physician has been notified of the recertification, has issued orders for the new

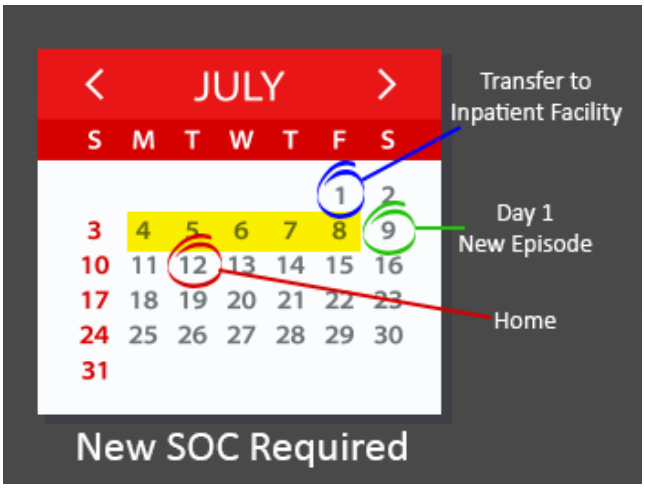
certification period, and is aware of other components of the home care plan. This can be done by faxing the plan of care to the physician and receiving verbal or written verification from the physician of confirmation of the orders. These details, including communication with the physician, should be recorded in the clinical record prior to the first billable visit in the new certification period.

Recertification or Resumption?

If a patient is transferred to an inpatient facility and resumes services during the 5-day recertification window (between days 56 and 60 of the ending episode), **only the resumption of care assessment needs to be completed.** The recertification assessment is not required. A recertification assessment should never follow a transfer assessment.

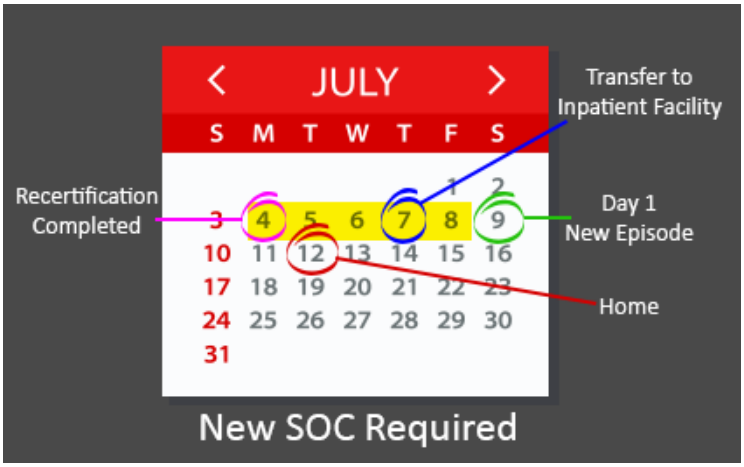
The resumption assessment will be used to determine the payment for the new episode. In this situation, a Plan of Care (485) would also need to be generated and sent to the physician for signature.





A patient who is transferred to an inpatient facility and does not resume services within the 5-day recertification window should have a new start of care assessment (RFA 1) completed when discharged from the facility. A discharge OASIS assessment (RFA 9) is not required, although clinicians may need to complete agency-specific discharge paperwork. The transfer assessment completed at the time of admission to the inpatient facility is all that is required.

A patient who undergoes a recertification assessment during the last five days of the certification period but then is admitted to the hospital **before a visit can be made in the new certification period** should also have a start of care assessment completed instead of a resumption of care assessment when discharged from the facility. As in the previous scenario, a discharge OASIS assessment (RFA 9) is not required.



Estimate of Length of Skilled Services

Effective 5/11/2015 (Change Request 9189), the recertification plan of care must include a physician statement estimating how much longer the skilled services will be required. This statement is part of the certification for continued services and must be signed by the physician.

22. Goals/Rehabilitation Potential/Discharge Plans

Sacral pressure ulcer close to less than 3 cm in diameter by 8/12/2016 and will heal without signs of infection by 10/1/2016. Patient will be discharged when pressure ulcer has healed and family is able to manage skin care safely and independently.

23. Nurse's Signature and Date of Verbal SOC Where Applicable:	25. Date HHA Received Signed POT
Nancy Nurse, RN	
24. Physician's Name and Address Donald Doctor MD 123 Hospital Blvd. Atlanta, GA 30303	26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan. I certify that in my estimation continued services will be required for 75 days.
27. Attending Physician's Signature and Date Signed Donald Doctor, MD	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Form CMS-485 (C-3) (02-94) (Formerly HCFA-485) (Print Aligned)

While the statement may be generated by the agency within the plan of care, there should be evidence in the clinical record that serves as evidence of the discussion between the agency and the physician regarding the estimation of how much longer the skilled services will be required. Although the agency may document the expected length of service for the physician to sign, the time frame must be based on the physician's estimate not the agency's estimate. The estimate provided can be longer than 60 days; however, this date will need to be reviewed and updated with the next recertification.

To meet this requirement, an actual statement must be included on the plan of care. The agency cannot simply use the duration of physician orders as the estimate. CMS does not mandate where the statement is placed; however, it does need to appear either within the certifying statement or on the plan of care that is signed by the certifying physician.